DRAFT PA Criteria

Initial Approval: October 10, 2018
Revised Dates: January 9, 2019

CRITERIA FOR PRIOR AUTHORIZATION

Calcitonin Gene-Related Peptide(CGRP) Antagonists

PROVIDER GROUP: Pharmacy

MANUAL GUIDELINES: All dosage forms of the following medications will require prior authorization.
Erenumab-aooe (Aimovig™)
Fremanezumab-vfrm (Ajovy™)
Galcanezumab-gnlm (Emgality™)

CRITERIA FOR INITIAL APPROVAL: (must meet all of the following)

- Patient has a diagnosis of chronic or episodic migraine
  - Chronic migraine: 15 or more headache days per month, for more than three months, which, on at least eight days/month, has the features of migraine headache
  - Episodic migraine: less than 15 headache days per month
- Patient must have experienced an inadequate response after a trial of at least one agent from each medication class listed in Table 2 at a maximum tolerated dose, OR have a documented intolerance or contraindication to all preventive therapies~~Patient must have experienced an inadequate response to a trial of two or more preventive therapies after titration to maximum tolerated doses (trial of at least 60 days), OR have a documented intolerance or contraindication to two or more preventive therapies. Preventive therapies include but are not limited to beta- blockers, calcium channel blockers, anticonvulsants, and antidepressants~~
- Patient must have experienced an inadequate response to a trial of onabotulinumtoxinA (Botox®) (trial of at least 60 days), OR have a documented intolerance or contraindication to treatment with onabotulinumtoxinA (Botox®), for chronic migraine treatment only.
- Prescriber must provide documentation of all previous medication trials. Documentation must include the medication name(s), trial date(s) and outcome(s) of the trial (i.e. inadequate response, intolerance or contraindication).
- Prescriber must attest that all medication-specific safety criteria, as defined in T~~t~~able 1, is met.

CRITERIA FOR RENEWAL:

- Prescriber must attest that all medication-specific safety criteria, as defined in T~~t~~able 1, continues to be met.
- The patient must meet one of the following:
  - The patient has experienced a reduction in the number of monthly headache days compared to baseline (prior to starting treatment with the requested agent)
  - The patient has experienced a reduction in the number of monthly headache days of at least moderate severity compared to baseline (prior to starting treatment with the requested agent)

LENGTH OF APPROVAL: 6 months

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TABLE 1. MEDICATION-SPECIFIC CRITERIA

MEDICATION-SPECIFIC CRITERIA	
Ajovy™ (fremanezumab-vfrm)	• Patient must be ≥ 18 years of age • Dose must not exceed either 225 mg (1.5 mL/1 syringe) per month OR 675 mg (4.5 mL/3 syringes) every 3 months
Aimovig™ (erenumab-aooe)	• Patient must be ≥ 18 years of age • Dose must not exceed 140 mg (2 mL/2 syringes) per month
Emgality™ (galcanezumab-gnlm)	• Patient must be > 18 years of age • Dose must not exceed 240 mg (2 mL/2 syringes) for initial dose and 120 mg (1 mL/1 syringe) for maintenance dosing

TABLE 2. PRIOR PREVENTATIVE MIGRAINE THERAPIES

BETA-BLOCKING AGENTS	ANTIEPILEPTIC AGENTS
Propranolol	Topiramate
Metoprolol	Valproic acid
Timolol	Divalproex

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DRUG UTILIZATION REVIEW COMMITTEE CHAIR

_____
DATE

_____
PHARMACY PROGRAM MANAGER
DIVISION OF HEALTH CARE FINANCE
KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT

_____
DATE